

QUESTIONNAIRE FOR APPLICANTS REQUESTING SPECIAL ACCOMMODATIONS

Request and documentation must be received 60 days prior to exam administration. Along with this questionnaire, you must include supporting documentation verifying your disability.

Documentation requirements:

1. Must be submitted on official letterhead and signed by a licensed professional qualified to make an evaluation;
2. The evaluation must be made no more than three years prior to the examination date and include a history of previous accommodation;
3. Should establish the existence of a “disability” within the meaning of applicable law;
4. Should describe how the resulting functional limitations impact the individual’s ability to take the examination;
5. Should demonstrate the need for an accommodation;
6. Should specifically identify the accommodation(s) that are believed to be appropriate.

Your completed questionnaire and documentation must be mailed to: Special Accommodations Coordinator, ELS&S, P.O. Box 541, Alpharetta, Georgia, 30009. **DO NOT MAIL THIS FORM OR THE SUPPORTING DOCUMENTATION TO THE BOARD.**

Please type or print.

1. Name: _____
Last First MI
2. State in which you seek registration: _____
3. Exam date you are requesting accommodations for (circle one): April October
4. Which specific exam are you seeking accommodations for: _____
5. Have you taken this exam before? Circle one. Yes No
6. Did you receive special accommodations for the exam? Yes No
7. Date of birth: _____
8. Social Security Number: _____
9. Address: _____

10. Daytime telephone number: _____

11. Nature of disability: (circle one)

Hearing impairment

Learning disability

Physical disability

Visual disability

Psychiatric disability

Other: _____

12. In order to document your need for accommodation as completely as possible, please attach, in addition to professional documentation, a personal statement describing your disability and its substantial limitations on one or more of your major life activities.

13. How long ago was your disability first professionally diagnosed? Circle one.

Less than 1 year

1-2 years

2-4 years

5 or more years

14. What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability. The accommodation must be validated on the supporting documentation by the licensed medical doctor or licensed psychologist. Please circle all that apply.

Additional testing time

Assistance:

Reader

Proctor Assistance (recorder of answers)

Sign Language Interpreter (for spoken directions only)

Separate test room

Other: _____

15. If you are requesting additional time, please circle the amount of time **as supported by your documentation**:

1 hour per session

Time and one half

Double time

Other (please specify) _____

16. Prior classroom or test accommodations that you have received:

A. Standardized Examinations:

_____ Month/Year _____ / _____

Accommodations Received: _____

(If extra time, note amount given: _____)

B. College: _____

If yes, accommodations received: _____

C. Secondary or elementary school: _____

If yes, accommodations received: _____

17. Authorization:

If clarification or further information regarding the documentation is needed, I authorize the NCEES to contact the doctor(s) who diagnosed the disability and/or those entities that have provided me test accommodations. I authorize such doctor(s) and entities to communicate with the NCEES in this regard to provide NCEES with such clarification and/or further information.

Signature _____ Date _____